Description of Baseline Survey

The American College of Nurse-Midwives Healthy Birth InitiativeTM Reducing Primary Cesareans ("RPC") is now recruiting hospital teams to join the 2018 cohort of the multi-hospital collaborative. All hospitals who wish to apply to the RPC 2018 multi-hospital quality improvement learning collaborative must complete this baseline assessment.

This assessment asks for information about your institution, and also contains a set of questions about your team's culture and readiness to participate in quality improvement initiatives.

Before completing this assessment, please review the Bundles at http://www.birthtools.org/RPC-Bundles-Toolbox .

Benefits for your hospital: After completing the baseline assessment your hospital will receive a free copy of "SUPPORTING HEALTHY AND NORMAL PHYSIOLOGIC CHILDBIRTH: A CONSENSUS STATEMENT BY ACNM, MANA, AND NACPM"

Completing this survey will provide ACNM with valuable data, which will help shape future ACNM work in RPC. All data will be kept confidential and ACNM will only discuss the results of the survey in the aggregate.

1. Name of person completing survey:

2. Email and phone number contact information for person completing survey

3. Name of hospital where you attend births:

4. Street address, including city/state where hospital is located

5. My current profession is

- CNM
- MD
- RN

6. Are you a member of ACNM?

- Yes
- No

7. Does your hospital use an EMR for documentation of care? If so, please select the vendor?

- ◯ No
- ◯ Allscripts
- ◯ Amazing Charts
- ◯ AthenaHealth
- ◯ Centricity
- ◯ Cerner
- ◯ Digicharts
- ◯ eClinicalWorks
- ◯ e-MDs
- ◯ Epic
- ◯ Greenway
- ◯ Maternity Neighborhood
- ◯ McKesson
- ◯ Medents
- ◯ Medical Mastermind
- ◯ MediNotes
- ◯ NextGen
- ◯ Practice Fusion
- ◯ Practice Partner
- ◯ Private Practice
- ◯ QuadraMed
- ◯ Sage
- ◯ SOAP Notes
- ◯ Watchchild/Hill-Rom

Other: Please specify which EMR your hospital uses

8. Can you get data reports from your EMR customized to your needs? You may check all that apply.

- [ ] No
- [ ] Yes, reports of aggregate data (such as total # of births, episiotomy rate) from a data or IT specialist.
- [ ] Yes, can run my own reports of aggregate data (such as total #of births, episiotomy rate).
- [ ] Yes, can export de-identified patient-level data into another program (e.g. Excel) to prepare the data

9. Does your dept have access to support for modifying the EMR or reports from the EMR?

- [ ] I am not sure
- [ ] No
- [ ] Yes, within our department
- [ ] Yes, within the IT department of the hospital

10. Which of the following do you use to track/compile patient-level data or clinical statistics? Please check all that apply.

- [ ] EMR
- [ ] paper birth log
- [ ] spreadsheet (e.g. Excel or Google Docs)
- [ ] mobile app
- [ ] data collection tool provided by your hospital/practice
- [ ] data collection tool provided by a state or regional entity (such as a quality collaborative, Medicaid program)
- [ ] BirthTracks
- [ ] MANAStats
- [ ] AABC Perinatal Data Set
- [ ] We do not track track clinical statistics or patient level data

Other (please specify)

11. Do you have a secure file sharing site on all your computers in the obstetric unit (e.g. Sharefile)?

- ( ) Yes
- ( ) No

12. How many births were done in your hospital in 2016? Please provide the number of births.

13. How many primary cesarean births were done in your hospital in 2016? Please provide the number of primary cesareans.

14. Do you collect variables needed to measure NTSV cesarean? (Cesarean birth in Nulliparous women with one baby at term in the head position: Nullip, Term, Singleton, Vertex)

- ◯ Yes
- ◯ No

If Yes, how many NTSV births occurred in your hospital in 2016?

15. If yes, how many NTSV cesareans were done at your hospital in 2016?

16. Does your hospital provide access to VBAC?

- ◯ Yes
- ◯ No

17. If yes, do midwives participate in the care of women laboring after cesarean?

- ◯ Yes
- ◯ No

18. If no, rank the following in order of importance.

	Resources for emergency cesarean delivery are NOT “immediately available.”
	Risk Management or malpractice carriers will not permit VBAC.
	Physicians are not comfortable with this option.

19. Which type of providers conduct deliveries in your hospital? Check all that apply.

- ☐ Ob/Gyn
- ☐ CNM/CM
- ☐ Family and Community Medicine
- ☐ Physician's Assistant
- ☐ Resident

20. Do you attribute* cesareans by type of provider?

*Attribution refers to assigning the "incident of care", in this case cesareans, to the provider who was primarily involved in providing care. Hospitals may have an attribution process that assigns the cesarean birth to the provider who cared for the woman prenatally, during labor, or both.

- ◯ Yes
- ◯ No

21. If not, do providers keep case lists of patients they manage?

- ◯ Yes
- ◯ No

22. If not, why?

- ◯ Resources for emergency cesarean delivery are not “immediately available.”
- ◯ Our risk management department will not permit this
- ◯ Providers are not comfortable with this option
- ◯ Other (please specify)

23. Do you have unit policies or clinical guidlines established for the following:

Please check all that apply. If not the exact name of your policy, please check those closest to your situation.

- ☐ Intermittent Auscultation
- ☐ Interpretation of category 2 tracings
- ☐ Standard definition of active labor
- ☐ Definition of lack of progress/arrest
- ☐ Time parameters for review of 1st or 2nd stage labor progress
- ☐ Oral hydration and nutrition during labor
- ☐ Doula Support
- ☐ Non-narcotic pain support
- ☐ Pharmaceutical pain support

24. How would you characterize your hospital?

- ◯ Academic Teaching Hospital-Providers (usually all employed by the affiliated university or in some cases hospital). Attending providers supervise the care of Ob/Gyn and/or family practice residents and in some cases nurse-midwifery students. In this model, the nurse-midwives may follow their own caseload of patients in addition to supervising the residents.
- ◯ Private Practice/Community Hospital- MDs and CNMs have delivery privileges in a hospital. These may be integrated practices with CNMs and MDs employed by the same group or in some cases a self-employed midwifery group with consultation agreements with an MD group. May include hospitalists. Maternity care providers who admit to the hospital agree to have their clients' labors managed by the hospitalist. The Hospitalist may be a CNM or an MD, again depending on individual hospitals.
- ◯ Staff HMO (e.g., Kaiser) CNMS and MDs all care for the same group of patients and the care of any individual may shift between MD and CNM not based on the needs of the client but the staffing needs of the hospital.
- ◯ Mixed Public-Private Practice/Community Hospital Some providers are employed by the hospital. Private practice groups have delivery privileges. May utilize hospitalists in the management of some/all patients.
- ◯ If none of the above please describe in your own words.

25. What is the payor mix of your hospital? (choose one)

- ◯ > 80% private insurance
- ◯ Closed panel or staff model HMO (i.e. Kaiser)
- ◯ >80% Public insurance (medicaid or state funded)
- ◯ Mix of public/private payors

26. If mixed:

- ◯ Weighted toward publically funded (>50%)
- ◯ Weighted toward privately funded (>50%)

27. Racial and Ethnic Data- Please state the approximate percentages (entered as a whole number without the % sign) of clients giving birth in your obstetric unit. Use numbers only, Answers must add up to 100.

American Indian or Alaskan Native (i.e. Navajo, Mayan, Tlingit, etc.)

Asian (i.e. Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Hmong, Laotian, Thai, Pakistani, Cambodian, etc.)

Black or African American (i.e. African American, Haitian, Nigerian, etc.)

Hispanic, Latino, or Spanish origin (i.e. Mexican, Mexican American, Puerto Rican, Cuban, Argentinian, Colombian, Dominican, Nicaraguan, Salvadorian, Spaniard, etc.)

Native Hawaiian or Other Pacific Islander (i.e. Native Hawaiian, Guamanian or Chamorro, Samoan, Fijian, Tongan, etc.)

White (i.e., European, Middle Eastern, Northern Africa, etc.)

Some other race or origin

28. The culture of physiologic birth in our department is:

- ◯ Strong among providers, nurses and the administration.
- ◯ Tentative: some providers, adminstrators and nurses are supportive and others are resistant.
- ◯ The dominant culture in our unit does not support physiologic birth.

Definition of physiologic birth: Spontaneous labor and birth at term without the use of pharmacologic and/or mechanical interventions for labor stimulation or pain management throughout labor and birth.

29. Shared decision making* is practiced at our institution:

*process in which clinicians and patients work together to make decisions and select tests, treatments and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values

- Always
- Most of the time
- Sometimes
- Rarely

30. There is a respectful and positive relationship among the providers in our department.

- Always
- Most of the time
- Sometimes
- Rarely

31. Each professional is respected for their speciality or area of expertise.

- Always
- Most of the time
- Sometimes
- Rarely

32. When there is a disagreement about the clinical management of a client, nurses, midwives and physicians follow an agreed upon process of communication to find a solution.

- Always
- Most of the time
- Sometimes
- Rarely

33. Senior leadership/clinical management in my organization rewards clinical innovation and creativity to improve patient care.

Strongly disagree Neither agree nor disagree Strongly agree

34. Senior leadership/clinical management in my organization solicits opinions of clinical staff regarding decisions about patient care.

Strongly disagree | Neither agree nor disagree | Strongly agree

35. Senior leadership/clinical management in my organization seeks ways to improve patient education and increase patient participation in treatment.

Strongly disagree | Neither agree nor disagree | Strongly agree

36. Senior leadership/clinical management in my organization provides effective management for continuous improvement of patient care.

Strongly disagree | Neither agree nor disagree | Strongly agree

37. Senior leadership/clinical management in my organization provides staff members with feedback/data on effects of clinical decisions.

Strongly disagree | Neither agree nor disagree | Strongly agree

38. Senior leadership/clinical management in my organization hold staff members accountable for achieving results.

Strongly disagree | Neither agree nor disagree | Strongly agree

39. Staff members in my organization have a sense of personal responsibility for improving patient care and outcomes

Strongly disagree | Neither agree nor disagree | Strongly agree

40. Staff members in my organization cooperate to maintain and improve the experience of care

Strongly disagree | Neither agree nor disagree | Strongly agree

41. Staff members in my organization are willing to innovate and/or experiment to improve clinical procedures.

Strongly disagree | Neither agree nor disagree | Strongly agree

42. Staff members in my organization are receptive to change in clinical processes

Strongly disagree | Neither agree nor disagree | Strongly agree

43. In general, in my organization, when there is agreement that change needs to happen (select all that apply)

- [ ] We have the necessary support in terms of budget or financial resources.
- [ ] We have the necessary support in terms of training.
- [ ] We have the necessary support in terms of facilities.
- [ ] We have the necessary support in terms of staffing.

44. In general, in my organization, when there is agreement that change needs to happen, Senior leadership/clinical management will (choose all that apply):

- [ ] Propose a project that is appropriate and feasible.
- [ ] Provide clear goals for improvement in patient care.
- [ ] Establish a project schedule and deliverables.
- [ ] Designate a clinical champion(s) for the project.
- [ ] We have not discussed this.

45. Have you ever participated in a formal data-driven perinatal quality improvement (QI) collaborative?

- ( ) Yes
- ( ) No

46. If Yes, what were the QI issues addressed by the collaborative? Please check all that apply.

- [ ] Prevention of Postpartum Hemmorhage
- [ ] Reduction of elective deliveries < 39 weeks
- [ ] Reduction of elective deliveries 39 weeks to 41 6/7 weeks
- [ ] Hypertensive disorders of pregnancy
- [ ] Prevention of VTE

Other (please specify)

47. Have you identified current practices or policies that may be associated with increased cesarean rate? If yes, please describe.

48. Have you considered alternative policies/practices to reduce cesareans? Please describe.

49. Do you have a multidisciplinary team that meets to address quality issues?

- ( ) Yes
- ( ) No

50. Does your team have access to quality improvement tools and support?

- ( ) Yes
- ( ) No

Thank you!

Thank you for taking the time to complete this survey. Click on the link to receive your copy of SUPPORTING HEALTHY AND NORMAL PHYSIOLOGIC CHILDBIRTH: A CONSENSUS STATEMENT BY ACNM, MANA, AND NACPM.